Identifiable Data Set for Hospital Outpatient Prospective Payment System (OPPS) Description, Fields, and Definitions

FILE DESCRIPTION

This file contains select claim level data and is derived from 2005 hospital outpatient PPS claims, updated through December, 2005, that is, claims for services furnished on or after January 1, 2005, through December 31, 2005 that were received, processed, paid, and passed to the National Claims History file by December 31, 2005. This file includes more than 54 million claims, for services paid under the OPPS, including observation, multiple and single claims. This is a flat file available on cartridges. The record length is 10277, blocksize is 32760.

Requests for clarification of file description, layout, and definitions only can be accepted at (410) 786-0378.

FILE LAYOUT

XR00.@DBT0992.NPR7.OPPSBEF1.T0060518

FILE NAMES

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01  PUF-DATA.
   10  PUF-TYPE                          PIC X(4).
   10  PUF-PROVIDER-NUMBER               PIC X(6).
   10  BILL-TYPE                         PIC X(2).
   10  FROM-DATE                         PIC S9(5) COMP-3.
   10  DIAGNOSIS-CODES                   PIC X(50).
   10  OUTLIER-PAYMENT                   PIC S9(9)V99 COMP-3.
   10  SERVICE-LINE-COUNT                PIC S9(3) COMP-3.
   10  SERVICE-LINE-GROUP.
      15  SERVICE-LINE
            OCCURS 0 TO 300 TIMES
              DEPENDING ON SERVICE-LINE-COUNT.
       25 SERVICE-REVENUE-CODE            PIC X(4).
       25 SERVICE-HCPCS                   PIC X(5).
       25 SERVICE-MJMC                    PIC X.
       25 SERVICE-DATE-OFFSET             PIC S9(3) COMP-3.
       25 SERVICE-UNIT-COUNT              PIC S9(7) COMP-3.
       25 SERVICE-TOTAL-CHARGES           PIC S9(9)V99 COMP-3.
       25 SERVICE-COST                    PIC S9(9)V99 COMP-3.
       25 SERVICE-REV-PAYMENT             PIC S9(9)V99 COMP-3.
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CLAIM AND SERVICE LINE FIELD DEFINITIONS:

CLAIM FIELD DEFINITIONS

Please note that CMS has revised the logic that we used to determine what is considered to be a major procedure versus a minor procedure. We refer readers to the narrative claims accounting document, which can be found on the OPPS Website, in order to understand the methodology employed.

TYPE: The claim type is either multi-major (MMAJ), multi-minor (MMIN), single major (SMAJ), single minor (SMIN), or observation (OBSV). These claim types are defined as:

MULTI-MAJOR: Claims with more than one separately payable procedure and/or multiple units of "major" procedures, (n=24,713,294). (These are examined carefully in stage 3 for dates of service and content to see if they can be divided into simulated or "pseudo" single claims.)

MULTI-MINOR: Claims with multiple HCPCS, multiple services on the same date of service, and/or that have multiple units of one or more procedure codes with status indicator N, (n = 44,858).

SINGLE MAJOR: Claims with a single unit of one separately payable procedure (SI= S, T, V or X, which are called "major" procedures), all of which will be used in median setting, (n=29,684,668).

SINGLE MINOR: Claims with a single unit of a single HCPCS to which we assigned the status indicator of N (packaged item or service) (n=40,111). We retain this file as insurance against last minute changes in packaging decisions

MULTI-MAJOR: Claims with more than one separately payable procedure and/or multiple units of "major" procedures, n=24,713,294. (These are examined carefully for dates of service and content to see if they can be divided into simulated or "pseudo" single claims.)

MULTI-MINOR: Claims with multiple HCPCS, multiple services on the same date of service, and/or that have multiple units. These claims cannot be considered to provide the costs of a single separately payable procedure without examining dates of service, n=44,858. (For example, pathologies are packaged unless they appear on a single bill by themselves. The multiple minor file has claims with multiple occurrences of pathology codes, with packaged costs that cannot be appropriately allocated across the multiple pathologies. However, in examining dates of service under Stage 3 below, a claim with multiple pathologies may become several "pseudo" single claims with a unique pathology on each day. These pseudo singles for the pathology codes would then be considered a separately payable for rate setting purposes.)

SINGLE MAJOR: Claims with a single unit of one separately payable procedure (which is called a "major" procedure), all of which will be used in median setting, n=29,684,668

SINGLE MINOR: Claims with a single HCPCS that is not separately payable (which is called a "minor" procedure), n=40,111. These claims may have a single packaged procedure or a drug code. We retain this file as insurance against last minute changes in packaging decisions.

OBSERVATION: Claims with HCPCS G0244 billed

PROVIDER-NUMBER: The identification number of the institutional provider certified by Medicare to provide services to the beneficiary.

BILL-TYPE: The code derived by CWF to indicate the type of claim submitted by an institutional provider.

FROM-DATE: The date of service in quarter/year format

DIAGNOSIS CODES: The principal ICD-9-CM diagnosis code, followed by other diagnoses, identifying the diagnosis, condition, problem or other reason for the outpatient encounter/visit shown in the medical record to be chiefly responsible for the services provided.

OUTLIER-PAYMENT: 2005 outlier payment. Value is zero if there is no outlier payment.

SERVICE-LINE-COUNT: The number of revenue codes appearing on the claim.

SERVICE LINE FIELD DEFINITIONS

SERVICE-REVENUE-CODE: The provider-assigned revenue code for each cost center for which a separate charge is billed. A cost center is a division or unit within a hospital (e.g., radiology, emergency room, pathology). Revenue center code "0001" is used to identify the claim "totals" line.

EXCEPTION: Revenue center code 0001 represents the total of all revenue centers included on the claim.

SERVICE-HCPCS: Healthcare Common Procedure Coding System (HCPCS) code for an item or service, is a collection of codes that represent procedures.

SERVICE-MJMC: Each HCPCS code has an indicator for one of the flowing three classifications: J = major; M= minor; B = bypass. This indicator is used to sort the claims into the following groups: single majors, multiple majors, single minors, multiple minors, and non-OPPS claims.

SERVICE-DATE-OFFSET: the number of days from the actual claim date of service. The actual claim date of service is not provided except in quarter/year format, and can be

found in the “FROM-DATE” field. This “SERVICE-DATE-OFFSET” field can be used to determine when line items were provided in comparison to other line items on the claim. The value “-999” will be used to indicate that the original line date of service was missing from the data.

SERVICE-UNIT-COUNT: The number of units of the item or service delivered.

SERVICE-TOTAL-CHARGES: The total charges (covered and non-covered) for all accommodations and services (related to the revenue code) for a billing period before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided.

SERVICE-COST: The charges adjusted to cost using the hospital’s specific cost center cost-to-charge ratio

SERVICE-REV-PAYMENT: The computed 2005 OPPS payment for a line item based on the payment APC. The “payment APC” refers to total payment, including deductible, coinsurance, and program payment.